UKDPC
UK DRUG POLICY COMMISSION

and analysis together
to inform UK drug policy

By their fruits...

Applying payment by results to drugs recovery

Dr Marcus Roberts, Director of Policy and Membership, DrugScope

---

This briefing reviews the possible impacts of the introduction of payment by results to fund treatment and recovery services for problem drug users. It outlines how payment by results works, examines how payment by results has been used elsewhere, and discusses the issues and challenges that will affect its introduction for drug treatment.

This work is part of a wider UKDPC project considering the impact on drug services of a move towards greater localism in a period of financial austerity.

SUMMARY

BACKGROUND AND CONTEXT

Announcing the Spending Review in June 2010, George Osborne described reducing public spending as "the great national challenge of our generation", and declared that it was time to "think innovatively about the role of Government in society". The Spending Review Framework document criticised "top down performance management and too many politically motivated targets" while emphasising that "there can be no justification for spending public money … without considering the impact on the outcomes that people care about".

In this climate, the challenge for Government in securing drug treatment services is to deliver the outcomes that people care about, provide good value for money and help to control public expenditure, while at the same time reducing the role of a centralised administration in setting targets, commissioning services and managing performance. The Government has a particular interest in 'payment by results' as a potential mechanism for achieving this, and is launching pilot programmes in six areas, using payment by results to commission services to deliver 'recovery'.

This UKDPC briefing considers the background to these plans, and identifies some of the opportunities and challenges of this approach to funding services.

CURRENT EXPERIENCE OF PAYMENT BY RESULTS

Payment by results (PbR) is an approach to allocating resources to services that rewards activity or outcomes. Payment depends on what the service does or achieves, for example, on how many hip replacements it performs or how many people it gets into sustainable employment. A payment by results approach underpinned the reforms to the National Health Service that were introduced in 2002. Beginning with a limited number of elective procedures, hospitals have

increasingly been paid on a 'per case' basis depending on the numbers of patients they treat, according to prices that are fixed nationally.

Payment by results has since been introduced into other policy domains. In 2003 the Department of Work and Pensions piloted 'Pathways to Work', a programme to move people on incapacity benefits into employment, which has been rolled out nationally since 2005. Private and voluntary sector organisations are paid by Government depending on their effectiveness at finding people jobs.

In September 2010, the Ministry of Justice and Social Finance Ltd launched an innovative Social Impact Bond pilot at Peterborough prison, under which Government will pay a return to social investors if their investment in projects run by charities delivers reductions in re-offending of a set amount.

PAYMENT BY RESULTS FOR RECOVERY: ISSUES AND CHALLENGES

There is general consensus about the importance in drug treatment of developing a focus on outcomes, with a particular emphasis on recovery and social integration. There are, however, a set of issues that will need to be addressed around the application of payment by results for drug treatment:

- Getting the outcomes and tariffs right will be critical. These will need to include a range of outcomes and take into account 'distance travelled' as well as the different starting points of clients coming into services. Further challenges include allowing for different local conditions, determining at what point an outcome has been achieved, and whether results are measured at the individual or the cohort level.
- Given that many people in substance misuse services have multiple needs, recovery requires holistic approaches and cooperation between services. It is important that payment by results encourages collaboration between sectors and services, and is not simply a spur to competition between them.
- The means by which outcomes are achieved are important, as well as the end results. Government and other statutory agencies will need to maintain some regulatory role, with reference to ensuring compliance with clinical and evidential standards.
- While it is intended that payment by results will introduce a market approach, allowing competition from private and third sector providers, it is not always clear that smaller organisations would be able to compete in this market, particularly if payment is entirely outcome based.
- There is concern that such a substantial change to policy systems could create perverse incentives. It will be important for Government to use the pilot programmes to explore different models with appropriate evaluation, and a willingness to recalibrate in response to the findings.
- The system of payment and reward could allow organisations to 'game' the system. In particular, contractors may focus on those clients who are closest to achieving desired outcomes, and provide only a bare minimum of support for those who are harder to help.

- While these perverse effects can be addressed by recalibrating the outcome and tariff structures, there may be a tendency for bureaucratic systems to develop in order to manage the system.
- Customer choice is expected to help drive payment by results. While this is supported, there is some doubt about how it will operate if clients choose services that are not most effective in delivering the outcomes set by the Government.
- Workforce development will be an important component of any successful shift towards a more recovery-focused approach; the funding arrangements should provide for the necessary investment in training and workforce support.
- There is concern that some harm reduction work – like needle exchange – could be neglected by an approach that focuses extensively on recovery and reintegration.

CONCLUSIONS

There is wide support for a more outcome-based system of funding and purchasing services, and for a greater focus on recovery and social reintegration. The direction of travel is welcomed, but the devil is in the details.

There are a number of questions that are not resolvable in any neat or straightforward way: the expectation is that the policy process will necessarily have a degree of messiness.

There is a good case for a gradualist approach to the transition to payment by results and for mixed systems (at least to start with) that combine payment for activities and outcomes. UKDPC supports evidence-based approaches to policy and practice development that are driven by careful research and detailed analysis. This requires a gradualist approach that provides space for effective systems to form and develop over time, and for approaches to be reviewed and reconsidered in the light of the emerging evidence.

A cautious approach combined with thorough and robust evaluation is of particular importance given that the approach being taken to payment by results in recovery is going into uncharted territories and is effectively a social experiment with a particularly vulnerable group.

1. BACKGROUND

On the 15 September 2010, the UK Drug Policy Commission (UKDPC) held an expert seminar on 'Utilising payment by results in drug treatment and recovery services' at the headquarters of Barclays Bank in London. The event was chaired by Professor Alan Maynard, a UKDPC Commissioner and a member of the Department of Health's External Reference Group for Payment by Results. It considered plans to introduce a 'payment by results' (PbR) approach to the funding of drug and alcohol treatment.

This work is part of a broader UKDPC project looking at the development of 'Localism' in a period of fiscal constraint. It attempted to draw together the lessons on the development of payment by results within the Department of Health and Department of Work and Pensions, as well as involving participants from the Ministry of Justice.

Presentations were given by:

- Paul Hayes (Chief Executive of the National Treatment Agency),
- Andrew Street (Professor of Health Economics at York University and Director of the Health Policy Team in the Centre for Health Economics),
- Maria Hudson (Senior Research Fellow at the Policy Studies Institute, University of Westminster),
- Martin Campbell (Deputy Director of PbR Development, Department of Health),
- Rob Owen (Chief Executive, St Giles Trust),
- Carole Green (Project Director, The Care Pathways and Packages Project, Yorks and North East England),
- Colin Bradbury (Head of Delivery, National Treatment Agency), and on video by
- A. Thomas McClellan (former Deputy Director and Chief Scientist, White House Office of National Drug Control).

The speakers joined other participants at the seminar for group discussions on the risks, challenges and opportunities of a payment by results approach to drug treatment. Participants at the expert seminar represented a wide range of Government departments and agencies (both statutory and non-statutory), including policy specialists, researchers and service providers. A list of participating organisations is shown in the Annex to this report.

This UKDPC briefing describes the context and background to the Government plans to develop the use of payment by results for drug services (including for people with drug dependence in the criminal justice system), and considers some of the risks, opportunities and challenges of this approach to funding services drawing on the presentations and discussions at the event.

2. THE POLICY CONTEXT

Announcing the Spending Review in June 2010, the Chancellor of the Exchequer, George Osborne, described reducing public spending as "the great national challenge of our generation", and declared that it was time to "think innovatively about the role of Government in society".[1] The Spending Review Framework document criticised "top down performance management and too many politically motivated targets" while also emphasising that "there can be no justification for spending public money … without considering the impact on the outcomes that people care about".[2]

The Government has been critical of centralised bureaucracy and has championed a radical shift in control over public money from national government to local decision makers, to enable them to allocate resources in a more flexible way, and to be responsive to local needs and priorities. It advocates the further extension of market mechanisms to increase efficiency. In their 'Programme for Government', the Coalition Government promised that they would "promote the radical devolution of power and greater financial autonomy to local government and community groups".[3] The introduction by the Prime Minister and Deputy Prime Minister celebrated an approach to health reform that would combine "Conservative thinking on markets, choice and competition" with "Liberal Democrat belief in advancing democracy at a much more local level' to produce 'a united vision for the NHS that is truly radical".[4]

The impact of central targets and their effectiveness as a means of performance managing services to deliver 'the outcomes that people care about' has been a particularly controversial issue in drug policy.

The current system for delivering drug treatment, which has been overseen by the National Treatment Agency for Substance Misuse (NTA) since 2001, has been highly successful in meeting national targets. The National Audit Office report on 'Tackling Problem Drug Use' (2010) concluded that the effectiveness and value for money of drug treatment was demonstrated by robust evidence.[5] The number of adults entering drug treatment has more than doubled in the past decade, waiting times are down to about a week on average and the overwhelming majority of people who enter drug services stay for 12 weeks or more, which is the time period that has been identified by clinical research as the minimum required for effective treatment. The NTA explains in its Business Plan for 2010-11, that the systematic referral of offenders into treatment is "preventing millions of crimes each year".[6] This focus has been consistent with community concerns and public priorities.

It has been objected, however, that too narrow a pre-occupation with "process-focused targets" has had perverse effects, and the comparatively low numbers of

---

[1] HM Treasury (June 2010), 'Spending review 2010 – The Government's approach' at www.hm-treasury.gov.uk/press_10_10.htm
[2] HM Treasury (June 2010), 'The Spending Review Framework', p. 5, 8.
[3] HM Government (May 2010), 'The Coalition: Our Programme for Government', p. 11
[4] Ibid, p. 8.
[5] National Audit Office (March 2010), 'Tackling problem drug use', Report by the Comptroller and Auditor General, HC 297 Session 2009-10, p. 8.
[6] National Treatment Agency (2010), 'NTA Business Plan 2010-11', p. 3.

people completing drug treatment and emerging drug free has been highlighted. For example, the Centre for Social Justice published a 'Green Paper on Criminal Justice and Addiction' in July 2010, which declared that "local commissioners and drug treatment providers work within an unhelpful and unambitious target culture" that has encouraged them to "focus on … moving addicts into treatment and processing them through a 12 week course of, usually, maintenance prescription".[7] In short, the accusation has been that an excessive focus on getting people *into* drug treatment and *keeping* them engaged has been at the expense of a commitment to getting people *out* of drug treatment and moving them *on* with their lives – for example, rebuilding family relationships, accessing safe and secure housing and entry into education, training, employment and other forms of meaningful activity. In particular, some commentators have criticised drug treatment services for what has been perceived as an excessive reliance on long-term 'maintenance' prescribing of so-called substitute drugs, and an insufficient focus on achieving drug free outcomes.

The need for a more outcome focused approach to drug treatment, and the importance of recovery and re-integration, is now all but universally accepted. For example, in March 2008, UKDPC held a two day meeting in Sussex that brought together people involved with drug services and policy in different ways to develop a consensus statement on recovery – a meeting that was facilitated by Professor Thomas McLellan who had been the prime mover in the Betty Ford Institute Consensus Panel in the United States. There was a consensus that recovery journeys were individual, and that different people needed different interventions at different points in their recovery journey. There was also agreement that drug services needed to be more ambitious and aspirational for service users, thinking of positive benefit and not just the minimisation of harm, and with a greater focus on social (re)integration. The definition of recovery agreed by the UKDPC Recovery Consensus Group stated that "the process of recovery from problematic substance misuse is characterised by voluntarily-sustained control over substance use which maximises health and well-being and participation in the rights, roles and responsibilities of society".

In a similar vein, the NTA Business Plan for 2010-11 acknowledges that "too often, the opportunities presented by engagement with treatment are squandered by a lack of ambition and a willingness to routinely write off the potential for dependent drug users to assume full roles as citizens".[8] It welcomed the Government's commitment to reform as providing "the spur for the cultural and structural change that is necessary to rebalance the system".[9] In January 2010, the NTA published guidance on 'Commissioning for Recovery' which - quoting the last Government's 2008 drug strategy - explicitly stated that the ultimate aim of treatment was to work with service users to achieve abstinence from their drug or drugs of dependency, and shifted the focus to successful exit from treatment and support for recovery and for social reintegration.[10]

---

[7] Centre for Social Justice (July 2010), 'Green Paper on Criminal Justice and Addiction', p. 15.
[8] NTA (2010), op cit, p. 3
[9] Ibid
[10] NTA (2010), 'Commissioning for recovery – Drug treatment, reintegration and recovery in the community and prisons: a guide for drug partnerships'.

The current method for allocating resources to drug treatment rewards local partnerships financially for the numbers of people either in effective treatment or subject to planned discharge free of clinical dependency. The NTA Business Plan 2010-11 makes a commitment to develop and implement proposals to incentivise successful completion of treatment. A new resource allocation and performance management framework is promised that will focus on the numbers leaving treatment free of clinical dependency, planned exits from treatment, injecting cessation, reduction in the use of 'index' drugs, abstinence from 'index' drugs and non-re-presentation for treatment following relapse. The statistical architecture needed to support this shift of focus has been developing over the last five years, with the development of the National Drug Treatment Monitoring System (NDTMS) and the introduction of the Treatment Outcome Profile (TOP). TOP was designed for use with individual clients as part of the case management process to monitor changes in substance use, injecting risk behaviour, crime and offending, and health and social functioning (mental health, education and employment and housing). However, it is based on self-report and hence may be unsuitable for underpinning payment by results, as it is neither an independent or objective assessment.

3. Explaining Payment by Results

The Government has announced that the National Treatment Agency will be abolished in 2012, with its principal functions taken over by a new Public Health Service. It is highly doubtful that the new Public Health Service will continue to allocate a national pooled treatment budget within a performance management and accountability framework based on centralised targets. This would be inconsistent with the Government commitment to localism and its conviction that improvement in the delivery of public services will depend on extending the role of 'markets, choice and competition'.

The challenge for Government is to incentivise drug treatment services to deliver the "outcomes that people care about", provide good value for money and help to control public expenditure, while also reducing the role of a centralised administration in setting targets, commissioning services and managing performance.

The Government has a particular interest in 'payment by results' as a potential mechanism for achieving this. The UKDPC seminar that provides the foundation for this report was held at a time when the Minister of State at the Cabinet Office, Oliver Letwin, was leading a cross-governmental initiative, bringing together ministers and officials from key departments with the aim of introducing a number of payment by results pilots for drug service provision in 2011.

Payment by results is an approach to allocating resources to services that rewards specific activity or outcomes. Payment depends (to a greater or lesser degree) on what the service does or achieves – for example, on how many hip replacements it performs or how many people it gets into sustainable employment. A payment by results approach underpinned the reforms to the National Health Service that were introduced by the previous Government in 2002. Beginning with a limited number of

elective procedures in 2003, hospitals have increasingly been paid on a 'per case' basis depending on the numbers of patients they treat, according to nationally-specified prices (or tariffs) for treatments, procedures, or bundles of treatment (in 2007-08, the tariff for providing a stomach-related diagnostic test was £407 and the price for a coronary bypass was £7,375, for example[11]).

Payment by results has since been introduced into other policy domains. In 2003 the Department of Work and Pensions piloted 'Pathways to Work', a programme to move people on incapacity benefits into employment, which has been rolled out nationally since 2005. Private and voluntary sector organisations are paid by Government depending on their effectiveness at finding people jobs. Under a system of outcome-based contracting, these 'prime contractors' receive 30% of the agreed price in monthly instalments, but the remaining 70% is outcome-based, with 50% depending on job outcomes, and 20% on job sustainment.[12]

More recently, on 10 September 2010, the Ministry of Justice and Social Finance Ltd launched an innovative Social Impact Bond pilot at Peterborough prison, under which Government will pay a return to social investors – including the Esmee Fairbairn Foundation and Barrow Cadbury Trust – if their investment in projects run by charities, such as the St Giles Trust, delivers reductions in re-offending of a set amount.[13]

These initiatives will be discussed below, but first it is helpful to consider in more detail how payment by results works, with particular reference to NHS services, as this is where it has been most developed.

ALTERNATIVE PAYMENT MODELS

Annual budget regimes

Payment by results has been developed within the NHS as an alternative to 'annual budget regimes', the more established method for allocating resources for public services. The service provider has traditionally received a fixed amount of funding to provide a service over a fixed time period. One approach is a 'block contract': a total price for providing the service is agreed in advance, with no specification of the expected volume of activity.

---

[11] Kings Fund Briefing (October 2007), *Payment by results*, Kings Fund, London, p. 2

[12] For more information, see Maria Hudson et al (2010), 'The influence of outcome-based contracting on provider-led pathways to care', Research Report No 638, Department for Work and Pensions. See also the Pathways to Work section of the DWP webpage at www.dwp.gov.uk/policy/welfare-reform/pathways-to-work

[13] A helpful briefing on the first Social Impact Bond Scheme has been published by the House of Commons Library: Strickland P (12 November 2010), 'Social Impact Bonds – The pilots at Peterborough Prison' at http://www.parliament.uk/briefingpapers/commons/lib/research/briefings/SNHA-05758.pdf
Social Impact Bonds are explained on the Social Finance website at http://www.socialfinance.org.uk/services/index.php?page_ID=15
The Ministry of Justice press release announcing the Peterborough pilot is at http://www.justice.gov.uk/news/announcement100910a.htm

The PCT and the hospital would often attempt to agree an annual budget by using the formula:

Budget = expected number of clients X local price per typical client

In reality, the calculation of the local price was often based on the provider's estimate of the budget needed to cover the existing costs of staff, facilities and so on, which was then divided by anticipated client numbers. This introduced a kind of circularity. The budget-setting process did not inherently involve any scrutiny or analysis of the cost-effectiveness or results of the methods or standards of service provision.

An annual budget regime gives the funder a high degree of control over expenditure and the provider a high degree of certainty about the budget available within the contracted period, because the total budget for the year is agreed between them in advance (and there was often an assumption that this would form the starting point for negotiations in future years). It does not guarantee good value for money for the commissioner (the service provider may work with fewer clients than anticipated or their needs may be less severe). Nor is there any incentive within the contracting process for the provider to improve efficiency or effectiveness (for example, if the local price is higher or the outcomes are poorer than in other areas of the country).

'Simple' or 'activity-based' payment by results

The reforms introduced into the NHS in 2002 make payment dependent on the *actual* number of clients who are seen by the service, not the anticipated or intended numbers.[14] The amount paid for each client depends on the tariff for the particular treatment, procedure or package of care they receive. First, patients are classified into groups who are expected to require similar care packages ('healthcare resource groups' (HRG)), then the price per client for each HRG is set on the basis of a national average price. So, the payment formula is:

Income (not budget) = actual number of clients of type j X national price per client of type j

The principal aims of introducing this approach were explained as:

- Facilitating the achievement of waiting time reduction targets in a decentralised way (by incentivising increased activity)
- Rewarding efficiency and quality of provision (by incentivising hospitals to reduce costs that exceed the tariff rate, and requiring them to reinvest in hospital services where costs are below the tariff, there has also been an assumption that if prices are standardised, providers will compete on quality)
- Supporting patient choice of provider by allowing money to follow patients
- Providing a transparent and fair way of paying providers for NHS care

[14] For a useful summary and analysis of the development of payment by results in the National Health Service see Maybin J (October 2007), 'Payment by Results', Briefing, Kings Fund, London.

- Reducing the transaction costs and negotiating disputes over price between PCTs and hospitals.[15]

The use of a national average price is viewed as an incentive for those operating above that price to review the effectiveness and efficiency of their practice. Alternatively, a price can be set that is believed to reflect good practice in delivery of that kind of care (for example, average price in what are independently assessed as the best performing hospitals).

Which ever way it is calculated, in this model the payment is essentially activity-related. It does not depend on achieving outcomes or results for the patient other than the treatment or procedure.

One problem with this approach is finding ways to control expenditure. As one participant in the UKDPC seminar explained "as a former chairman of a hospital, what we used to do is just maximise and increase activity rates. If you increase your activity rates you increase your revenue flow … (it was thought that) by fixing prices you would fix expenditure, but, of course, health providers can respond by changing their volume levels".

Outcome-based payment by results

Mixed outcome PbR

Proponents of outcome-based payment by results will often advocate a mixed approach, where the total payment depends on both activity and outcome.

In this case the price paid per client in each HRG includes a fixed price element as before but also an outcome-based element, which may be a true outcome (such as inpatient mortality following acute myocardial infarction) or quality indicators (such as, for the same condition, being discharged on aspirin).

The formula for allocating resource becomes:

Income = actual number of clients of type j X fixed price per client of type j
X p (outcome based payment per client of type j)

In this formula, p represents the weighting of the outcome based component which may vary.

This retains the focus on outcomes for clients and provides services with scope for innovation, while ensuring that payments more closely reflect the anticipated costs of the activities likely to produce the desired results than under a pure outcome model, and there is a greater level of predictability for both commissioners (or purchasers) and providers.

Pure outcome-based PbR

[15] Department of Health (2002b), *Reforming NHS Financial Flows. Introducing Payment by Results* (DH London).

On a pure outcome-based system, there would be no payment for activity as such, and the level of the payments would not therefore be based on activity cost at all (that is, on estimates of the costs of a treatment, procedure or intervention). On this approach

Income = the number of clients who achieve outcome j X the fixed price for outcome j

This introduces a high degree of flexibility enabling services to take different approaches to working with clients, which can encourage innovation and creativity. It also, and obviously, incentivises services to focus on their positive impact on the client's welfare.

The advantages and challenges of outcome based forms of payment by results will be examined in detail in the next section of this paper with particular reference to drug treatment, and detailed reference to issues raised in discussion at the UKDPC seminar.

4. OTHER ISSUES FOR PAYMENT BY RESULTS

INTERMEDIATE APPROACHES AND SUBSIDIARY STRATEGIES

This summary of some of the principal models does not do justice to the wide range of approaches that might be developed, which could combine elements of these different approaches in different ways and introduce a variety of mechanisms to deal with their potential shortcomings.

For example, the problem of **controlling total expenditure** in a payment by results system might be dealt with by introducing a cap - for example, no payment or a reduction in payment for each client above a certain ceiling. Martin Campbell, Deputy Director of Payment by Results Development at the Department of Health, explained in his presentation that the NHS had recently introduced a marginal rate of 30% of the full tariff for additional emergency admissions above a set level in order to "get a cap on rising activity levels in a constrained financial system".

Similarly, one of the criticisms of payment by results is that **outcomes may be unachievable for some (potential) clients**, at least within an acceptable time frame. This could be addressed by including a scale that could measure progress *towards* or *approximation* to the desired outcome (often referred to as a 'distance travelled' measures), with the level of payment depending on performance against this scale.

There are also alternative approaches to **making the transition *between* different funding and purchasing regimes**. An obvious example is whether or not new regimes are piloted, and, if so, what range of approaches are considered and compared through the piloting process. In addition, a change to funding and purchasing may be phased in over time. For example, in the first year 10% of total funding could be allocated through payment by results, in the second year 20%, and so on. Martin Campbell explained that the development of payment by results in the NHS had involved a four year transition period before the national pricing structure was fully applied, in order to enable service providers to adapt gradually to differences between established local prices and the new national tariffs (which, for some treatments in some areas, were substantially less).

A period of transition can also allow for ongoing assessment of the impact of a major change in financial structures at each stage in the process, including picking up on any perverse incentives or unintended consequences. It provides scope for review and recalibration of the overall system of funding or purchasing services as it develops. Alternatively, a 'big bang' approach can be taken.

MARKETS, COMPETITION AND CHOICE

In his presentation at the UKDPC seminar, Colin Bradbury, Head of Delivery at the National Treatment Agency, observed that the current arrangements for the allocation of the pooled treatment budget could be described as "a simple payment by results system". The amount received by local drug partnerships depends on their performance against NTA targets. A centralised performance management and

commissioning approach can be combined with payment that reflects the level of activity and/or outcomes. Colin Bradbury also reflected on the impact of variable local factors (such as conditions in housing and job markets) on the ability of service users to achieve recovery outcomes, and observed that these needed to be acknowledged, and factored into any outcome-based approach to funding.

The outcome-based component of the NTA's current commissioning system may be an effective way of incentivising local agencies to deliver the outcomes that people care about, but it may be missing some of the vital ingredients of 'payment by results' as it is understood by the Government.

Paul Hayes, Chief Executive of the National Treatment Agency, pointed out that the Government has approached payment by results as a potential mechanism for harnessing market disciplines to improve the delivery and efficiency of public services, and to enable innovative third- and private-sector providers to compete on an equal footing with the statutory services. The vision of ministers is that this will enable Government to provide universal services, specify outcomes and control overall expenditure, without relying on what are regarded as inefficient and inflexible central bureaucracies.

The 'archetype' of payment by results would appear to fit better with outcome than activity based payments. The process for setting appropriate tariffs for 'activities' (including treatment interventions) will necessarily make reference to the evidence base and be grounded in current practice. A system that focuses primarily on outcomes (rather than activities) is not directive about modalities, activities and approaches, and could therefore create more space for innovation and competition.

Paul Hayes proceeded to argue that the challenge for drug treatment was to reconcile this theoretical model of how 'payment by results' might be applied with the reality of established systems in which drug services are commissioned to deliver recognised evidence-based treatment within a tight regulatory framework. A pure 'payment by results' system would appear to be 'evidence neutral' because "if you believe you know what works as a commissioner then that in itself will tend to inhibit innovation". Such a construct would assume that providers competing in the market place have a strong incentive to ensure their services are evidence-based, in order to achieve the outcomes rewarded in a payment by results system as effectively and efficiently as possible. The theory would be that client choice between multiple providers will help to provide checks and balances through market mechanisms that are currently enforced by regulatory regimes.

Paul Hayes then went on to describe how the NTA will be working with Government departments to put the vision into practice by developing a series of workable proposals that will be tested in pilot schemes. A background assumption of the discussion was that the design and implementation of funding and purchasing systems had a profound effect on the activities undertaken by service providers, and on the effectiveness, efficiency, quality and the experiences of and outcomes for service users. As Paul Hayes observed in his presentation "we know from the experience of the NTA the extent to which you can manoeuvre the system by financially rewarding some activities and not others". A debate about how our

approach to financing drug treatment (and related) services could most effectively incentivise improved quality and outcomes (and avoid unanticipated and perverse outcomes) was welcomed.

DEVOLVING RESPONSIBILITY AND RISK

Payment by results approaches may also vary depending both on who has the purchasing power and how results are owned and rewarded within the system. For example, in the Pathways to Work scheme, the 'prime contractors' are directly commissioned by the Department of Work and Pensions and are paid for achieving employment outcomes. In practice, much of the service delivery is sub-contracted to small, specialist providers. The prime providers are free to reach their own agreements on how sub-contractors are paid, so in this model many of the key service providers are not necessarily subject to payment by results.

This can be contrasted with the Social Impact Bond Pilot at Peterborough Prison. Investors pay into a Social Impact Bond fund that is used to finance the work of service providers working directly with prisoners and ex-prisoners to reduce their offending. If these services achieve the outcome of reducing re-offending by 7.5% over six years, then the *investors* receive a return or payment and if the providers fail to achieve the outcomes, then it is the *investors* who lose their money. The provider agencies themselves are not direct beneficiaries of payment by results, nor do they bear the financial risk.

Thus there are a wide range of different ways in which payment by results can operate. For example, a payment could be made for *each* service user who achieves a specified outcome or when a *proportion* or *percentage* of service users do so. It can be paid directly to the service or to a 'prime contractor' or 'social investor' who accepts the financial risk and receives any outcome-based rewards, or it could be paid to a local authority depending on the 'results' achieved in its area. Payment by results could operate in various ways at different levels within a whole system. For example, the government could pay the local authority for achieving outcomes for a specified percentage of clients, while the local authority used a 'prime contractor' to organise service provision and the 'prime contractor' paid individual services depending on their levels of activity.

A particular issue is the role of client or service user choice within a payment by results approach. This is presented as an essential element in a market mechanism that can incentivise quality and effectiveness. The implication is that purchasing power would (to some degree at least) reside with service users or that money will follow service users depending on their choices between services.

DRUG TREATMENT, REINTEGRATION AND RECOVERY

It is perhaps misleading to talk about payment by results for drug treatment, at least if this implies that the relevant activities and outcomes will be treatment outcomes, comparable to hip replacements, stomach related diagnostic tests or coronary by-pass operations. It is key to the Government's vision for drug policy that the outcomes that are set by a payment by results system will have a strong focus on

social harms and benefits, including education and employment, housing and crime reduction.

The previous Government's second 10 year drug strategy, 'Drugs: Protecting Families and Communities' (2008) promised a "radical new focus on services to help users to re-establish their lives". Achieving social (re)integration not only contributes to reducing poverty and social exclusion, but supports recovery from drug dependency and prevents relapse. This theme is taken up by the current Government in the 2010 Drug Strategy 2010 in which one of its three themes is "Building recovery in communities" and one of its two overarching aims is to "increase the numbers recovering from their dependence. It also calls for all services to be commissioned with a wide range of best practice outcomes in mind including, in addition to freedom from drug and alcohol dependence, prevention of drug related deaths and blood borne viruses, reduced offending, sustained employment, suitable accommodation, improved mental and physical health and wellbeing, improved relationships with families and friends, and the capacity to be a good parent.[16]

A payment by results approach to recovery therefore will need to engage and incentivise a range of services to work together to deliver outcomes for people in drug services, including, for example, housing providers, JobCentres and ETE services, mental health and social services. It will need to identify a range of measurable outcomes to ensure that purchasing systems and/or service delivery is responsive to complexity, and works holistically with clients to address their individual needs. The various outcomes will need to be weighted appropriately to incentivise recovery. For example, it was commented in the seminar that if the system was set up to enable contractors to secure profit simply by reducing crime "the easiest way to do this would be to get opiate-using acquisitive offenders on methadone, and then forget about them", which would be directly counter to the Government's vision.

This creates the challenge of how payments are to be effectively allocated between services and the ownership of outcomes. In his presentation, Colin Bradbury invited participants to consider two local areas that are both poor at moving drug users into employment. "In one area", he suggested, "this could be because the drug services are poor at helping people to recover from their addictions. But in the other area, it might be because the JobCentres are not good at working with people in recovery and moving them into jobs". A prime objective of any funding or purchasing system is to ensure 'fair' reimbursement (for example, by embodying a principle of equal pay for equal work) – if the system of payment is inequitable, it is likely to be unstable and ill-designed to promote efficiency and quality.

[16] HM Government (2010) *Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: supporting people to live a drug free life.* p20

5. Learning from Current Systems of Payment by Results

Drug and alcohol service users will be affected by payment by results initiatives across Government, including its further development in the NHS (for example, in mental health services), the 'rehabilitation revolution' in prisons and the criminal justice system and the continued development of outcome-based contracting within the welfare state. This report and the UKDPC seminar on which it is based, however, has a particular focus on the Cabinet Office led initiative to introduce pilots to develop payment by results for drug services in the community.

These proposals will take payment by results into new and uncharted territories:

1. The Government is reported to be planning a pure outcome-based version of payment by results in the pilot areas, with no element of payment either to maintain capacity or for levels of activity as such.
2. The current indications are that Government will identify the outcomes that qualify for payments across four 'domains' covering: overcoming drug dependency; offending; employment; and health and wellbeing. This will mean extending payment by results to work across often complex care pathways with multiple needs that can vary between individuals. Care pathways will involve a variety of providers.
3. If the Government is planning to introduce the pilots in 2011, then the timescales are exceptionally tight, particularly when compared with processes of transition in other NHS services.

The challenges of such an undertaking are brought into focus by considering the experience of developing outcome-based contracting and payment by results in other policy fields, and the lessons to be learnt from these.

Payment by results in NHS hospitals

Since 2003-04 payment by results has been developed in the National Health Service. Mandatory tariff payments now account for £26 billion of NHS spending: approximately a quarter of the NHS budget, and over 60% of income in acute trusts.[17] The payment by results system covers most care in foundation trusts, planned (elective) care in all NHS hospitals, non-elective and outpatient care, accident and emergency and minor injuries units. There are plans to extend payment by results to cover other NHS services, including mental health (see below).

However, as Andrew Street, Professor of Health Economics at York University, emphasised in his presentation "there is no outcome-based payment within payment by results in the healthcare sector at the current time – it is basically payment for activity". Martin Campbell, the Deputy Director of Payment by Results Development at the Department of Health, described the current approach as "a system to enable commissioners of care to pay providers (generally NHS hospitals) according to the

[17] As reported in Martin Campbell's presentation on 'Payment by results in the NHS' at the UKDPC seminar

number of patients treated and the complexity of their presentations, and using a national tariff or price list … it is a system for paying for a range of 'price tagged' activities". It is notable that the approach in the NHS to date has not driven the development of a market involving third or private sector provision. It is essentially a basis for funding hospital care that is intended to be fair and consistent, and to improve quality and efficiency.

A number of speakers highlighted the challenges of introducing a model based on the experience of the NHS for drug treatment. In his presentation, Professor Andrew Street explained that "payment by results can work well when you have a comparatively straightforward problem that requires a single intervention for a single provider", adding that "it has therefore worked best in acute care, which is where it has been introduced by most countries around the world".

A number of steps are necessary to create the basic architecture and currency for operating a payment by results approach using the model that has been applied in acute care.

1. Classifying activities. The NHS has identified around 1,400 Healthcare Resource Groups (HRGs), covering a wide spectrum of care and treatment within acute settings. The recent development of HRGs, for example, has included procedures in adult critical care, emergency medicine, pathology, radiology, chemotherapy, radiotherapy and specialist palliative care. HRGs have been defined as 'standard grouping of clinically significant treatments which use common levels of healthcare resources'.
2. Setting appropriate prices. In the transition period when payment by results was first introduced into the NHS there was a gradual shift from local pricing to national tariffs for HRGs. These prices have been based on average costs of delivering packages of care for each group of patients, based on extensive cost data provided by NHS Trusts. As mentioned earlier, there are plans to move towards tariffs that are based on 'good practice' pricing.
3. Allocating service users within this system. As Professor Andrew Street explained "the provider has an incentive to classify patients in the way that attracts the highest payment". Where a patient sits on the borderline between two or more HRGs, there will be an incentive to 'up-tariff'. There is a need for some independent mechanism or monitoring to ensure appropriate allocation of patients within the system.

There would be a number of technical problems in applying this approach to drug treatment and recovery. For example:

- Is there sufficient consensus in the drugs field on what constitutes an appropriate package of care for people with drug problems that would provide a basis for the identification of Health Resource Groups (or an equivalent to them)?
- Would it be possible to develop this approach to work with people with complex needs and who will often require services from multiple providers, including, for example, health and mental health, housing, employment support and social services?

- It was also argued that there is not sufficient data and information on costings for drug treatment and recovery to calculate national tariffs.

The work on recovery and care pathways that is being undertaken by Dr David Best for the National Treatment Agency (NTA) will contribute to mapping out these pathways and developing more nuanced understanding of the nature of the process of recovery. The NTA explains that Dr Best is considering ways to segment the treatment population to enable commissioners and providers to direct users towards tailor-made programmes which encourage them to take ownership of their own future to achieve independence and recovery from addiction. He has commented that "we aim to produce evidence-based guidance on typical pathways to recovery and the characteristics of the recovery journeys that are undertaken by clients in this country. That will enable us to match treatment and supporting services much more closely to the users who will benefit from them".[18] This work could potentially contribute to determining care packages and tariffs for the development of payment by results for drug and alcohol treatment.

Another important contribution to the mapping of care pathways for people with substance misuse problems is the Royal Society of Arts report 'Whole person recovery: A user centred approach to problem drug use', which was launched as part of the RSA's Connected Communities project in November 2010, and based on extensive work in two areas of East Sussex (Crawley and Bognor Regis) involving service users. It seeks to help to provide "a catalyst for users themselves, and members of their communities, to foster recovery through their collective social effort and innovation". It makes "a case for recovery-oriented initiatives and services that are more personalised, better balanced between psychosocial and medical interventions and better able to draw on a whole-community response to the problems that lead to, or are prompted by, problematic drug and alcohol use".[19] It also illustrates the complexity of the recovery process and its non-linear nature.

MENTAL HEALTH

The Mental Health Care Pathways and Packages Project was undertaken by providers in mental health trusts in the Northern and Yorkshire Areas to inform the options for establishing a payment by results system for mental health.[20] The Project Director, Carole Green, was able to report to the UKDPC seminar how it had:

- Developed a standardised assessment tool (mandated for national use from 01/04/2011);

---

[18] Reported on the NTA website at www.nta.nhs.uk/news-2010-businessplan.aspx

[19] Daddow R and Broome S (November 2010), ' Whole person recovery: A user-centred systems approach to problem drug use', RSA Projects, Royal Society of Arts, London, p iv.

[20] The discussion of Payment by Results for mental health services draws on Carole Green's presentation to the UKDPC seminar. For further discussion of the first phase of this project, see Department of Health (2006), 'Mental Health Payment by Results – Care Packages and Pathways Project, Stage 1 Final Report, at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074519

- Developed 21 care clusters that reflect the needs of working age and older people with mental health problems that are to be used as currency (analagous to HRGs in acute care) (also mandated for national use from 01/04/2011); and
- Used existing indicators and outcome measures linked specifically to each of the 21 clusters to establish on outcome focus to currency development

They are also developing an algorithm to be part of the IT system that can use the scores from the needs assessment tool (mental health clustering tool) to generate a cluster allocation that 'best fits' the scores. This would not replace the practitioner/service user decision making but could provide validation for commissioners that the majority of cluster allocations follow the expected pattern. This might help to mitigate against the gaming or up-coding that has been a negative feature of some PbR systems.

In 2012-13, the use of the clusters will become mandatory for contracting and payment purposes, but the tariffs will be set on the basis of local pricing, which will mean that there is not the incentive to improve practice given by average or good practice pricing. The earliest possible date for introducing a national tariff for mental health would be 2013-14, and it is recognised that it might not be possible to identify national prices at all. As Professor Andrew Street explained, "in mental health, patient characteristics explain little of the variation in the costs of providing services to patients in the same clusters between Trusts and local areas, which seems to be largely explained by providers doing different things with the same patients, with a lack of consensus on what constitutes good practice". This would apply also to drug treatment, recovery and social reintegration.

The experience of developing payment by results in mental health is of considerable significance for drug and alcohol services, given both the complexity of many of the clusters and care pathways involved in mental health, and the development of recovery as a core concept for the development of mental health services. The Care Package and Pathways Project has itself considered care pathways for people with drug and alcohol dependency and dual diagnosis.

A key message from participants involved in introducing payment by results in mental health was to allow sufficient time to develop the architecture and currency, and to "make sure everybody recognises that such a major shift will not happen over night". As one participant with experience in the NHS argued "if you don't proceed with caution with the fundamental building blocks and do not have those in place, you are going to introduce a system that will have perverse incentives running through it by design, and the costs of those perverse incentives could outweigh any benefits from payment by results".

Another message for drug treatment was "not to be afraid of complexity". It was argued that "the payment system will need to be quite sophisticated because the care that is delivered is sophisticated. A simply payment by results system that is too "one size fits all" is not going to incentivise good practice and reward providers fairly. The payment system, because of the nature of the issues, is going to have to be

complex. Putting time and effort into ensuring that it reflects the complexity and the reality will yield long term benefits. I would not advise rushing in".

EVIDENCE FOR THE EFFECTIVENESS OF PAYMENT BY RESULTS

National Health Service

It is too early to reach any firm conclusions about whether payment by results in the NHS has delivered the anticipated benefits of increased efficiency, improved quality and greater patient choice.

A report produced by the Kings Fund in October 2007 explained that "as payment by results has been in place for only a short time, evidence on its impact is limited". It commented that

- International experience suggests pay-per-care financing systems lead to increases in hospital activity, but two early assessments in England had shown no strong evidence of this.
- A study in Sweden suggested that switching from a budget-based to an outcome-based system could reduce costs by around 13%, but interviews with early adopters of the system in England had not yielded information on the impact on efficiency.
- There was little evidence of impact on quality, although a study involving interviews with staff found that providers did not think that payment by results had yet stimulated Trusts to compete on quality (it was comments that "PbR can only increase quality in combination with strong commissioning and the patient choice policy, both of which are in their early stages of development").
- Anticipated reductions in transactional and administrative costs had not so far been borne out.[21]

In 2008 the Audit Commission concluded that "payment by results has the potential to support real improvements in the appropriateness and efficiency of NHS healthcare", while adding "however, the policy will need continual monitoring, review and updating if it is to achieve that potential".[22]

In his presentation Martin Campbell from the Department of Health commented that there was emerging evidence that PbR had resulted in a reduction of costs, and that there was no negative impact on patient care. He recognised that the effectiveness of the system in driving up quality could be enhanced where it was possible clearly to identify and incentivise good practice. The NHS is currently introducing 'good practice tariffs' for strokes, hip fracture, cataracts and removal of the gall bladder, because these are areas where there is strong clinical evidence on good practice (for example, "if you know that outcomes for patients who have had a stroke improve if they have an appropriate scan within 24 hours and then receive the right drugs, we can make an additional payment to incentivise Trusts to do this").

---

[21] Maybin J (October 2007), op cit,, p 4.

[22] Audit Commission (2008), 'The Right Result – Payment by Results 2003-07', Health National Report, p. 76.

Pathways to Work

The experience of developing a payment by results approach in the NHS can provide some guidance for drug treatment. It is, however, activity-based and with a focus on medical procedures and pathways, with little reference to social services and outcomes. The use of outcome based contracting in the welfare system provides an alternative point of reference.

As Maria Hudson, a senior researcher at the Policy Studies Institute, explained in her presentation, the Department of Work and Pensions has significant experience in engaging private and third sector providers in the delivery of welfare to work services, and with payment dependent on the employment outcomes they achieve. This work has focused on people on incapacity benefits (including those with disabilities and mental health problems), who may experience similar barriers to employment to people in drug services.

The evidence suggests that this approach has not been effective in incentivising engagement with clients with more complex problems. The 'prime providers' from the private and voluntary sector that have been contracted to deliver Pathways to Work have tended to focus on people who they identify as the closest to 'job ready' in order to meet targets. According to qualitative research conducted by Maria Hudson and colleagues (2010) this focus may have intensified in response to economic recession in 2009, which created a "very difficult environment in which to meet employment targets".[23] Nor did this research suggest that outcome-based contracting was driving innovation. Instead, providers in the local areas studied largely focused on reducing operational costs and achieving performance efficiencies.

In all the areas studied there was frustration among Pathways to Work advisors about what was perceived as management pressure to focus on job ready clients. The report explains that 'a strong sense of what needed to be done for business survival and job security saw creaming (working intensively with some clients) viewed as appropriate behaviour in a target setting environment. Parking (giving other clients a bare minimum of service) was seen as appropriate practice, where there was clear management steer, for disengaged clients lacking in motivation and for clients who were seriously ill or awaiting treatment'.

A number of lessons from Pathways to Work will be relevant to the development of payment by results for drug treatment, specifically:

- The need to look at the balance of power between prime providers and sub-contracted services (for example, if there is an incentive for prime providers to cream the most job ready clients)
- Stronger client or service user feedback mechanisms as a counterbalance to 'cherry picking' and 'parking'

[23] See Maria Hudson et al (2010), 'The influence of outcome-based contracting on provider-led pathways to care', Research Report No 638, Department for Work and Pensions.

- The impact of wider conditions on the behaviour of providers (for example, where recession makes it more challenging to deliver on employment targets)
- The development of payment systems that can differentiate client groups and pay providers on the basis of a wider range of outcomes to 'recognise the smaller steps that some of the client group can make in order to progress on a journey towards employment over time.[24]

The experience of Pathways to Work is highly pertinent to drug services, given the Government's intention to include outcomes relating to education and employment, the multiple problems that people in drug treatment will often experience and the formidable barriers to employment that they can face.

6. Payment by Results for Recovery: Issues and Challenges

There was a consensus at the UKDPC expert seminar on the importance of developing a focus on outcomes, with a particular emphasis on recovery (defined to include health and well-being, and participation in the rights, roles and responsibilities of society) and social reintegration (including housing, education, employment, and other forms of meaningful activity). It was accepted that drug treatment could be more effective than it currently is in helping people to get off and stay off drugs. It was agreed that crime reduction remained a key outcome for an effective drug treatment system that reflected public priorities and represented good value for public money. It was also agreed that we need a broader, more positive and less stigmatising vision of the role of drug treatment, which recognises the acute vulnerability and multiple needs of many people who develop serious drug problems.

A background assumption of the discussion was that the design and implementation of funding and purchasing systems had a profound effect on the activities undertaken by service providers, and on the effectiveness, efficiency, quality and the experiences of and outcomes for service users. As Paul Hayes observed in his presentation "we know from the experience of the NTA the extent to which you can manoeuvre the system by financially rewarding some activities and not others". A debate about how our approach to financing drug treatment (and related) services could most effectively incentivise improved quality and outcomes (and avoid unanticipated and perverse outcomes) was welcomed.

There were, however, a wide range of concerns about payment by results, with the principal issues identified and briefly discussed below. This is perhaps unsurprising given the limited evidence available on its impact in other policy spheres, and the extent to which Government plans for drug treatment could take payment by results into largely uncharted territories. It is hoped the richness of the discussion at the UKDPC seminar can contribute to the planning and design of the pilot models to ensure that they are as robust as possible.

[24] Ibid

KEY MESSAGES FROM DISCUSSION GROUPS

1. *Getting the outcomes and tariffs right*.
There was broad agreement on the need to include a range of outcomes, realised by individuals, families and communities.

It was suggested that the consensus statement on recovery that was proposed by the UKDPC's Recovery Consensus Group could provide an appropriate framework by dividing outcomes into two broad domains:

- 'voluntary control of substance misuse', which would encompass both abstinence-based and medically-assisted recovery, as appropriate to the individual at a particular time and point in the treatment journey.
- 'health and well-being and participation in the rights, roles and responsibilities of society', which could include housing, education and employment and reduced offending.[25]

One group suggested that the principal 'domain absolutes' for recovery could be drug free, crime free, in employment or training, good health and mental health, good family relationships and/or other networks, and evidence of positive social adjustment. There was consensus on the need to develop 'distance travelled' measures, to balance high aspirations with realism, and ensure that expectations of providers were fair and achievable.

One issue that emerged was the importance of calibrating a payment by results system to adjust appropriately to the different starting points of clients coming into services. For example, some may lack the confidence, self-esteem and basic skills to enter employment in the short term, while others will already be in work.

Five further issues for tariff setting and payment were identified at the UKDPC seminar.

i. Local v national tariffs.
It was argued that payments should be adjusted to take account of local conditions. Moving a service user into housing or employment, for example, will be less challenging in some localities (and at some times) than others, and this should be reflected in the payment system. One suggestion was that empowering local partners to develop local approaches would allow them to adjust tariffs to reflect local conditions – at least, in theory, as, in practice, it is unclear how local agencies would determine an appropriate set of local tariffs for outcomes such as reduced offending or access to education. However, there is also a potential cost to setting tariffs locally. In the NHS, the development of tariffs that are based on national average costs has been viewed as critical to driving improvements in performance.

[25] See UKDPC (July 2008), 'The UK Drug Policy Commission Recovery Consensus Group – A vision of recovery', available on the UKDPC website at www.ukdpc.org.uk

ii. The time period for outcome assessment
It is not yet clear at what point in time it should be decided that an outcome has been achieved. Equally, there is need to determine for how long evidence would be required that a service user had reduced drug use or maintained abstinence or stopped offending or sustained employment before the payment for these outcomes was released (and what kind of evidence would be needed). If payment is made too early there is a significant risk of subsequent relapse (or offending or loss of employment), but if it is held back for too long then services could receive payment for their work only months or even years after the service user has left. A need was identified for improved systems to track long-term gains and to verify improvement over time.

iii. Individual v cohort outcomes.
It is debatable whether outcomes should be measured at the individual or cohort levels. One approach would be to trigger a payment *each* time a service user achieves an outcome; alternatively it could be triggered if (and only if) a specified number or proportion of *all* service users do so. It was suggested that a cohort level approach could provide a corrective to the tendency for outcomes to reflect variations in the starting points, motivations and obstacles for different individuals – with these tending to balance out at the aggregate level. On the other hand, there is the question of how the incentives built into payment by results would operate once the service had reached the target number or proportion. It may also prove more difficult to incentivise services to be responsive to the particular needs of individual clients if the system of rewards is aggregative, not individualised.

iv. The weighting for different outcomes.
There will be a need to determine the balance of payments for achieving different outcomes. One approach might be to seek to incentivise services to focus more on outcomes that benefit the wider community. In which case, reduction in crime could attract a higher level of payment than abstinence from drugs, because it has a direct impact on other people.

v. Ascribing outcomes to different providers within a treatment system.
Where many providers contribute towards the outcome it will be necessary to determine how the system attributes success or failure to each contribution. If a drug service helps a service user to secure stable housing, and this in turn supports access to training or holding down a job, there will be a question about how payment will be allocated between the drug, housing support, training and employment services.

2. *Breaking down silos and incentivising holistic approaches.*
Many people in substance misuse services have multiple needs. The majority of clients of are experiencing some form of mental health problem. A significant proportion are former prisoners or are otherwise in contact with the criminal justice system. Most are unemployed and many are homeless or are living in insecure housing.

Recovery involves improvements in multiple domains – substance use, health, mental health, social functioning (including social networks, family, and other relationships), education, employment, and housing. It is typically a long process – and rarely a linear or straightforward one. Successful and individualised recovery journeys will require a variety of forms of support, from a number of services and sectors, contributing at different stages. It requires 'holistic' approaches and co-operation between services.

It is important that payment by results is set up in a way that encourages and supports collaboration between sectors and services, and is not simply a spur to competition between them. There is a particular risk that market competition elements of payment by results could undermine joined-up work at a time of sharp reductions in the funding available for public services, and increased competition for a diminishing pool of money, both between and within sectors. This could be exacerbated if there are not fair and transparent processes for allocating payments between services for their contributions to the achievement of outcomes. These need to recognise the 'added value' created by collaborative work that is built around the particular needs, resources, motivations and goals of individual service users, who often have multiple needs and are in contact with a range of services.

A further issue is the interactions between different payment by results systems where they are potentially working with the same service users (for example, a recently released prisoner falling within one of the 'rehabilitation revolution' pilots who is also participating in the Department of Work and Pensions' work programme).

3. *Not forgetting that processes and activities matter.*
A number of contributors emphasised that the means and methods by which outcomes are achieved are important as well as the ends and results. Where services are delivered within the NHS they should be subject to the same clinical and evidential standards as in any other area of NHS care – for example, compliant with guidelines produced by the National Institute of Clinical Excellence (NICE) and the rights and responsibilities that are set out in the NHS constitution.

This implies that central Government and other statutory agencies will need to maintain a regulative role, which involves reference to the evidence-base (as represented, for example, in NICE guidelines). One participant commented that, as a minimum, "we need to ensure that there is some mechanism for ensuring that if somebody is in treatment that is manifestly not meeting their needs, and the treatment deliverer is clearly failing to respond to the evidence that it is not working, we are able to intervene to rescue service users in that position".

Two related points were raised about the nature of the process. First, it is important that tariffs are set at a level that is sufficient to fund a choice of high quality treatments (for example, that can cover the cost of facilities of an acceptable standard and training and workforce development). The level at which payments are set will determine what approaches are possible, and will have an impact on the quality of provision. Second, it is important to protect and promote the role of client and service user choice in treatment (as well as families and carers where appropriate). The active involvement of service users in their own treatment and

care planning is important in building therapeutic relationships, motivation, developing personal responsibility and hence recovery. However, this does not mean that service users will always and invariably choose the interventions that are most effective in achieving goals that have been set by Government. It is said that client choice is considered to be a critical component of payment by results, but more needs to be done to spell out exactly how this will work.

4. *Fair competition.*
It is intended that payment by results will introduce a market approach, allowing competition from private and third sector providers, and that this will encourage innovation and creativity and drive improvements in efficiency and quality. The Government has expressed a commitment to expanding the role of the voluntary and community sector as part of its Big Society vision, with a particular emphasis on the potential contribution of smaller charitable organisations that are embedded in local communities.

There is scepticism that smaller voluntary and community sector organisations would be able to compete in this market, particularly if payment was entirely outcome based. While it is understood that the Government is planning to introduce loans to provide initial capital support to service providers before results-based payments are made, there is a real question whether smaller, local organisations will be prepared to take on loans and shoulder the associated risks. It was also argued that the payment by results system will need to be set up to discriminate between potentially effective and innovative local projects and less viable approaches.

One possibility is that larger providers will take on the role of 'prime contractors' and sub-contract to smaller organisations. A concern is that large private sector organisations could enter the market and effectively extract profit from the system for managing the risks inherent in outcome-based payment by results, leaving less investment available for improving frontline services. Nor is it yet clear from the evidence from the NHS or Pathways to Work that a payment by results system will necessarily focus competition between contractors and providers on quality, rather than simply cost-cutting, which may be a particular temptation in a more inclement financial climate. It is also unclear how the potential benefits of payment by results will be realised within the whole system if the 'prime contractors' subcontract on a different basis (for example, paying smaller agencies a block grant).

5. *Unintended and unanticipated consequences*
There was a general concern that such a substantial change to policy systems – and therefore to motivational structures – could create 'perverse incentives', as individuals and organisations responding rationally to those systems produce unanticipated and unintended consequences. This will be a particular challenge given the depth of the systemic and cultural changes envisaged by Government, within drug and alcohol services and, more broadly, with what could amount to a 'once in a generation' shift in the way that public services are delivered. As argued in the previous section, the development of a much more outcome and 'recovery' based version of payment by results will take us into new and uncharted territories, in which there is a high likelihood that we will encounter some unexpected problems. There was therefore strong support for the Government's commitment to piloting

payment by results approaches, and calls for Government to conduct meaningful pilots that explore different models with appropriate and thorough evaluation, and a willingness to recalibrate and redesign in response to the findings.

This will pose significant challenges for the effective development of payment by results approaches within each of the key policy domains – including the drug and alcohol treatment pilots, the Ministry of Justice's 'rehabilitation revolution' for offenders, the Department of Work and Pensions 'work programme' for the unemployed and the continued extension of payment by results approaches in the NHS (including for mental health). An additional layer of complexity is introduced by the potential inter-dependencies and interactions between these policy initiatives. It was asked at the UKDPC seminar, for example, whether different Government departments are working with compatible notions of recovery and what the protocols will be for operating payment by results where individual clients are engaging with services across these domains (for example, where someone has a 'dual diagnosis' of substance misuse and mental health issues).

These issues are compounded by the need to pilot payment by results during a period of wider policy change, including substantial reductions in public expenditure following the 2010 Spending Review, the shift of control over public service budgets from central to local government and the development of the Big Society programme.

6. *Removing the temptations for 'gaming' and 'playing the system'.*
One of the main causes of unintended consequences could be perverse incentives to 'play the system'. The risk is that if it is not carefully calibrated the system of payment and reward could incentivise rational organisations to behave in ways that do not deliver the desired outcomes for service users, families, communities or Government.

At the UKDPC event it was stressed that it is particularly important that we proceed with caution in implementing payment by results because locally the service architecture is fragile. Also the complexity of the area and our lack of understanding of what works for whom, means considerable work is needed on how to segment the population to prevent 'gaming', such as 'creaming' and 'parking'.

'Creaming' occurs when contractors who are paid by results focus on those clients who are closest to achieving those results. This tends to occur alongside 'parking', where the harder to help and those with more complex needs receive a bare minimum of support and make little or no progress toward(s) the desired outcomes.

Dr Maria Hudson explained that both of these perverse effects have been evident in the Department of Work and Pensions' 'Pathways to Work' programme. They appear to have been regarded by provider agencies as legitimate business strategies within an outcome-based funding environment, and the tendency to concentrate on the most 'work ready' service users had intensified in a tighter financial climate where job (and other) opportunities were scarcer.

7. *The (re)generation of bureaucracy*

Such perverse effects can be addressed by calibrating the outcome and tariff structures to incentivise services to engage with those clients with the most entrenched and/or complex needs. First, the tariff structures can be set up to pay a premium to services that achieve outcomes with these clients. Second, the outcomes or results can be specified in a way that recognises and rewards the achievement of intermediate goals (so-called distance travel measures), that are realistic and appropriate for those clients. It was argued, however, that the more sophisticated the outcomes and tariffs become – in order to prevent 'gaming' and ensure payments are allocated fairly – the greater the tendency for bureaucratic systems to develop in order to manage the system infrastructure, monitor outcomes and allocate payment.

In particular, it was suggested that introducing higher payments for clients with more complex needs could itself create opportunities for gaming. It incentivises services to describe and assess the clients that they are working with in a way that maximises – and may exaggerate – the severity of their problems. The obvious way to address this issue is to make provision for some sort of independent assessment process. One proposal that emerged from the discussion at the seminar was for the development of an Independent Care Management Service that would determine and review 'clusters' or 'classifications' (the equivalent of health resource groups, but capturing a complex mix of health and social problems), set tariffs, and oversee the allocation of clients within this system. However, this introduces a high degree of complexity into the system and a need for bureaucratic structures.

8. *Customers and markets*

It has been suggested that customer choice could help to drive payment by results, providing a counterbalance to a tendency to bureaucratisation and creating a more market-based system. While this was strongly supported in principle at the UKDPC seminar, questions were raised about how this would work in practice. It might be responded that customer choice is an essential element within payment by results for NHS acute services, and that this provides a model – but this was questioned.

With activity-based payment by results it is fairly clear how customer choice can help to drive the system, as the income of services depends directly on the number of service users they are able to attract (assuming there is choice between providers, levels of income over time will reflect customer choices). But it is not clear how this fits with a more outcome-based 'payment by results' approach. What happens, for example, if service users prefer or choose services that are not the most effective in delivering the outcomes that are set nationally by Government (for example, because they value other outcomes or aspects of service delivery)?

9. *Workforce development.*

It was commented that workforce development has tended to be a neglected issue within drug policy and will be an important component of any successful shift towards a more recovery-focused approach. Some promising workforce initiatives are emerging, notably the independent Substance Misuse Skills Consortium, which has the potential to contribute to the development of outcome-based and recovery-orientated practice and to shift attitudes and culture. It is important that the funding

and payment arrangements provide for the necessary investment in training and workforce support, and it was commented that central Government should have a role in workforce issues. A specific issue will be developing and supporting the acquisition of the skills and competencies that will be required by the 'new' workforce responsible for developing and managing payment by results.

10. *Harm reduction.*
While there was unanimous support for the recovery and reintegration agenda, a number of participants in the UKDPC seminar voiced concerns that the basic harm reduction work that is carried out by drug services should not be neglected. For example, the development of needle exchange has prevented thousands of problem drug users becoming infected with HIV/AIDS and hepatitis and can also be the starting point for greater engagement with services. There was a discussion of whether harm reduction activities and/or outcomes should be included within payment by results or would be better funded and supported separately. While there was not a clear consensus on this, the general view was that exclusion of harm reduction from the descriptions of outcomes for the payment by results pilots could result in the marginalisation of this work. The question was also raised of how payment by results could be adapted to support and incentivise the sort of early intervention and preventative work that is a central feature of the Government's approach to drug policy.

7. Conclusions

It might appear that the UKDPC seminar raised more questions than it answered. One of its objectives was certainly to contribute to policy formation by identifying issues that will need to be considered in developing payment by results for drug and alcohol services. However, it also supported a number of general conclusions, which appeared to be more or less unanimously endorsed by the many experts who participated, representing Government departments, academics and researchers, expert bodies, voluntary and community sector providers and the private sector.

First, there is wide support for a more outcome-based system of funding and purchasing services, and for a greater focus on recovery and social reintegration. The direction of travel is welcomed, but the devil is in the details.

Second, the discussions identified a number of questions that are not resolvable in any neat or straightforward way – the expectation is that the policy process will necessarily have a degree of messiness. For example, balances will need to be struck between potentially competing objectives in the absence of any clear guidance or evidence base, and where there may be no single right answer. An example is the trade off between the desirability of a simple and transparent system and that of specifying results and tariffs that are sufficiently nuanced and complicated to reflect what is achievable and fair in the allocation of reward.

It was noted that there are a number of examples of innovative outcome-based commissioning already in place or being developed within the drug treatment sector that could help to inform the development of models for piloting, and the commitment to 'genuine' pilots was welcomed.

Third, there was a high degree of consensus between separate discussion groups in their preference for a gradualist approach to the transition to payment by results and for mixed systems (at least to start with) that combine payment for activities and outcomes. The UKDPC supports evidence-based approaches to policy and practice development that are driven by careful research and detailed analysis. This requires a measured and gradualist approach that provides space for effective systems to form and develop over time, and for approaches to be reviewed and reconsidered in the light of the emerging evidence. This is the right approach to payment by results in this sector, which is necessarily, to some degree, a leap in the dark.

A cautious approach combined with thorough and robust evaluation is of particular importance given that the approach being taken to payment by results in recovery is going into uncharted territories and is effectively a social experiment with a particularly vulnerable group.

ANNEX:

ORGANISATIONS WHO PARTICIPATED IN THE WORKSHOP

In addition to the speakers listed on page 4 of this report and representatives from the UKDPC commissioners and staff, people from the following organisations took part in the workshop.

Action on Addiction
Association of Directors of Adult Social Service (ADASS)
Birmingham Drug and Alcohol Action Team
Burton Addiction Centre
Cabinet Office Strategy Unit
Centre for Public Innovation
Compass
CRI
Department of Health Offender Health
Department of Health, Substance Misuse Team
Doncaster and South Humber Mental Health NHS Foundation Trust
DrugScope
DWP (Labour Market Inclusion Division)
Essex Drug and Alcohol Action Team
GP (HMP Wakefield & RCGP Substance Misuse Unit)
Greater Manchester West Mental Health NHS Trust
Home Office Drug Strategy Unit
Home Office Offender-based Interventions
Institute of Psychiatry
Lancashire DAAT
Lifeline
Ministry of Justice
Nacro
National Treatment Agency
Office of David Burrowes MP
Phoenix Futures
RAPT
Social Finance
South London and Maudsley NHS Foundation Trust
St Giles Trust
The Alliance
Turning Point
White House Office of National Drug Control Policy Advisor

We are grateful to Barclays Bank and the Esmée Fairbairn Foundation for their support for this research.

ISBN 978-1-906246-31-0
This briefing is available at:
www.ukdpc.org.uk/publications.shtml#Localism